American Journal of Public Health
and THE NATION'S HEALTH

Volume 40 September, 1950 Number 9

Public Health Administration in Latin America*

M. E. BUSTAMANTE, M.D., DR.P.H.
Secretary General, Pan American Sanitary Bureau, Washington, D. C.

AVAILABLE information on Latin American public health organizations is scattered in a large number of publications, many not well known in the United States and Canada. They are written in Spanish, Portuguese, or French, and their distribution does not reach the reading desk of the public health workers, who form the majority of members of the American Public Health Association.

THE FIELD

There are, within the Latin American area, eighteen Spanish-speaking republics with 98,067,450 (1947) people; one Portuguese-speaking with 47,550,000 (1947); one republic with four departments "de la France metropolitaine et d'autre mer" where French is spoken, with a total of 597,359 inhabitants. Also within the area are several Dutch and English territories, with special types of public health administration, related to those of the mother countries.

The climate, the cultural background, the agricultural problems, the growing industrialization of Latin America, and the health problems are of great variety; the patterns of medical and public health organizations follow trends which at times appear familiar to North American workers and at times involve solutions due to different situations or at times due to strong personal influences. These differences are more apparent than in the United States, where schools of public health as a well defined educational force, are responsible for the orientation of programs and preparation of leaders.

THE PHILOSOPHY OF PUBLIC HEALTH ADMINISTRATION IN LATIN AMERICA

The European medical schools prepared, particularly in the 19th century and early in the 20th century, a group of clinicians, professors of internal medicine, surgeons, and bacteriologists, who brought to Latin America, medical specialization and guidance in anatomy, physiology, surgery, ophthalmology, cardiology, obstetrics, pediatrics, parasitology, and pathology. To this group belonged also the founders of the Bacteriological and Antirabic Institutes of

* Presented before the Health Officers Section of the American Public Health Association at the Seventy-seventh Annual Meeting in New York, N. Y., October 25, 1949.

South and Central America and Mexico. Hygiene was thought of as a subject of secondary importance and limited practical application.

The history of medicine and of public health, affected so clearly in the Anglo-Saxon countries by the two World Wars, shows also in Latin America the results of progress in the United States of America, since 1920 when the Rockefeller Foundation gave its first fellowships; a few years later the gradual influence of medical schools, hospitals, laboratories, medical, biological, and sociological centers of learning from the North is noticeable. The relationship of medicine and public health to social conditions, and the place of health among the elements of human progress and economic improvement are facts well accepted by public health workers in Latin America.

Every epidemiological study takes into account: population, family and social conditions, communications, agriculture, water supplies, housing, and medical services, with the study of disease prevention and control.

The studies of fellows at the schools of public health and their training visits to health departments and laboratories, divisions of maternal and child health, of statistics and epidemiology, of tuberculosis and of venereal disease control, have produced influences perceptible in Latin American departments of health. The thoughts of North American health workers have produced new ideas and variations of public health administration procedures which sometimes are quite different from the original concept of the United States organizations; as is the case, for example, when the "local health units" established in the United States or the "health or sanitary units" of many countries, reach a stage of broad expansion attained, for example, by the coördination in a unified technical and administrative unit embracing a complete state, of federal, state, and municipal health organizations, as in Mexico. The program of the "coördinated health services" in Mexico excludes as federal jurisdictional matters those relating to: international health relations; quarantinable diseases; pure food and drugs laws and regulations; control of narcotic drugs; but takes in: epidemiology and statistics; maternal and child health and welfare; environmental sanitation, food sanitation and control of food handlers, laboratory services, administration and preparation of budgets and all health units within the particular state. The coördination of national and local health services presented for the first time to the IX Pan American Sanitary Conference, held in 1934 in Buenos Aires, is a proposed topic for discussion at the XIII Pan American Sanitary Conference to be held in 1950 in the Dominican Republic.

Such coördination is needed because of the relations of national health services to state or provincial health services.

Three nations: Brazil, Mexico, and Venezuela, have states as sovereign political entities; Argentina has political and administrative autonomous provinces; other nations are not federal but central republics, and their local health organizations are more or less independent from the national health administration; in all countries, municipalities have certain rights and duties regarding health matters.

In general, the national Ministry deals directly with international health problems, quarantinable or pestilential diseases, control of narcotics, and purity of drugs, tuberculosis, venereal diseases, and malaria control, practice of medicine and national welfare institutions.

PLACE OF PUBLIC HEALTH ADMINISTRATION IN THE POLITICAL STRUCTURE

Every one of the twenty Latin American Republics has its national health organization under a member of the

Presidential Cabinet. In most countries the head of public health is a medical man and his official title is Minister of Public Health; in three countries: Costa Rica, Mexico, and the Dominican Republic, the equivalent title is Secretary of Public Health.

The Ministry dealing with hygiene includes social welfare in:

Costa Rica
Cuba
Chile
Ecuador
Guatemala
Mexico
Panama
Paraguay
Peru
Dominican Republic
Venezuela

Social security and health are in the same Ministry in Chile, Ecuador, Panama, and Paraguay.

Education and public health Ministers are designated in Brazil and Haiti.

In Panama, the Ministry includes Labor, Social Security, and Public Health, and Honduras includes: State, Justice, and Public Health.

Ministries of Hygiene or of Public Health, with no additional title, exist in Argentina, Bolivia, Colombia, Nicaragua, and Uruguay.

One country, El Salvador, has a General Direction of Public Health under the Ministry of Social Welfare.

There are fourteen General Directors of Health; two Under-Secretaries of Health; two of Health and Social Welfare, and two Ministers with no assistants for public health.

The large part taken by the welfare institutions, hospitals, asylums, and medical dispensaries is understandable when illnesses are prevalent and epidemic outbreaks are not rare; the treatment of diseases is a daily and urgent need and takes precedence; health and prevention are not of common knowledge and understanding, and the popular support exists for medical curative services and will remain so while suffering is obvious and immense and spectacular cures are not only demanded, but are possible, and appeal daily to the eyes and ears of millions of people.

The services for medical care are very close to the services for prevention. Frequently, public health units have as an integral part of their program, outpatient departments, running side by side with the ordinary health sections. A natural complement of a prenatal and postnatal program is a clinical and therapeutical department for infant medical care.

This development explains the numerous joint ministries of health and welfare and the two main administrative divisions under the minister: the general direction of public health and the general direction of public welfare.

An interesting observation related to the countries more advanced in modern public health administration, refers to the fact that countries having in the past one or more severe epidemic diseases have today a better concept, both professional and popular, of what public health organizations are and what they can do for the improvement of general conditions; on the other hand, countries with less serious epidemics in their medical history remain in a state of indifference or mild enthusiasm toward the role of preventive medicine.

Modern insecticides and new techniques for their application have proved to authorities and health workers that people do not accept insects as an inevitable evil. Today no population has refused, after its first observation, the visit of health inspectors, nurses, or doctors for the control of malaria and typhus; and the disappearance of mosquitoes, flies, lice, fleas, and cimex is becoming a daily common fact.

Health workers are moving fast toward new programs of immunization against smallpox, diphtheria, typhoid, and in certain areas, of immunization

GENERAL DEATH RATES

Deaths per 1,000 populations, 1946

Countries	*Rates*
Argentina	9.4
Bolivia *	14.8
Brazil †	17.8
Colombia	15.6
Costa Rica	12.9
Cuba ‡	10.6
Chile	16.6
Ecuador	17.2
El Salvador	15.5
United States	10.0
Guatemala	17.1
Haiti	....
Honduras	16.3
Mexico	19.4
Nicaragua	10.8
Panama	11.1
Paraguay	8.3
Peru	12.6
Dominican Republic	10.3
Uruguay *	8.1
Venezuela	15.0

* 1944.
† Rio de Janeiro and State Capitals only.
‡ 1945.
Compiled from official sources by the Statistical Section, Pan American Sanitary Bureau, October 21, 1949.

INFANT MORTALITY RATES

Number of deaths under one year per 1,000 live births, 1946

Country	*Rates*
Argentina	79.0
Bolivia	....
Brazil *	162.2
Colombia	150.0
Costa Rica	101.7
Cuba	....
Chile	142.8
Ecuador	133.0
El Salvador	113.0
United States	33.8
Guatemala	114.5
Haiti	79.2
Honduras	98.6
Mexico	111.0
Nicaragua	101.2
Panama	60.2
Paraguay	52.0
Peru	114.0
Dominican Republic	85.7
Uruguay	....
Venezuela	102.0

* Rio de Janeiro and State Capitals only.
Compiled from official sources by the Statistical Section, Pan American Sanitary Bureau, October 21, 1949.

against yellow fever. Malaria services are expanding in several countries; diseases other than those transmitted by insect vectors are under attack; and the word "eradication" appears more frequently in the programs. Countries which have active, well trained groups of public health workers are in the lead and are greatly interested in preparing their personnel by providing training centers and schools of public health.

Summarizing the obstacles and the constructive forces, we find among the difficulties:

Lack of recognition of public health as a career, with: (a) full-time personnel, (b) security of tenure, (c) adequate compensation.
Inadequate budgets for preventive medicine.
Size of problems depending on basic solutions: environmental sanitation, reduction of infant mortality.
Newness of concepts: prevention of disease, conservation of health.
Materialistic view of medical activities as a source of income, which draws the young graduates to the practice of medicine in cities and makes jobs a place not to serve but to gain additional income.

CONSTRUCTIVE FORCES

Good orientation of nucleus of professional health groups, many trained outside of their own countries.
New schools of public health, with sound programs for doctors, nurses, engineers, inspectors.
Strength of international public health coordination and coöperation.
Active and enthusiastic workers.
Awaking of interest in public health of political leaders and of the public, by the results of new insecticides and improvement of immunization procedures against childhood diseases.

RESULTS

Typical examples of accomplishments are:

Eradication of malaria in Chile and considerable progress in the Argentine Northwest, Brazil, and Venezuela.
Eradication of *Aedes aegypti* in Bolivia, areas of Brazil, and progress in almost every other Latin American country.
Reduction of typhus in Guatemala and Mexico.
International coöperation in sound, long-range programs, as the Institute of Nutrition of Central America and Panama, with the coördinating and partial financial support from the Pan American Sanitary Bureau.

THE FUTURE

National health administrations in Latin America are in a state of evolution, and progress is evident within each country, and local public health workers are well prepared and active.

The outside favorable forces are of different origins, most of them due to United States institutions and organizations, such as the United States Public Health Service; the Rockefeller Foundation; the Kellogg Foundation in recent years; the Institute of Inter-American Affairs; and for a long time the Schools of Hygiene and Public Health of the Universities of Johns Hopkins, Harvard, Ann Arbor, and recently of Minnesota; and the visits of professors from the United States to the southern countries.

The role of the Pan American Sanitary Bureau has been and is internationally very important, working since 1902 for the coördination of health activities, the exchange of information, the distribution of knowledge, and the creation of a consciousness of international relationship of responsibility of each nation for the health of other nations; a concept enlarged now by the World Health Organization, of which the Pan American Sanitary Bureau is the Regional Office for the Americas.

Regulations for Colored Margarine

New oleomargarine regulations of the federal Food and Drug Administration went into effect on July 1. The Act repealing the federal taxes on oleomargarine also indicates provisions to prevent the unannounced substitution of colored oleomargarine for butter on the market and in public eating places.

Oleomargarine on the grocer's shelves must be so labelled and every public eating place will be required to notify its patrons by conspicuous placards or on the menu, and also with the individual serving, if colored oleomargarine is served as a spread. In a number of states, however, the sale of colored margarine is still forbidden by state law.